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## **Abstract**

In response to the 2000 release of IOM's report To Err is Human, The Johns Hopkins Hospital (JHH) saw a need for a culture change. The JHH Patient Safety Committee created a safety program that focused on encouraging staff in selected units to identify and eliminate potential errors in the patient care environment. Senior hospital executives each adopted a critical care unit and worked with the unit staff to identify issues and empower staff to address safety issues.

The senior executive adopt-a-work unit program was successful in identifying and eliminating hazards to patient safety and in creating a culture of safety. This program can be broadly implemented. The keys to program success are the active role of an executive advocate and the willingness of staff to openly discuss safety issues on their unit. Regular meetings between the advocates and the units have provided a forum for enhancing executive awareness, increasing staff confidence and trust in executive involvement, and swiftly and effectively addressing areas of potential patient harm.

In this article we describe how we implemented this program, present case descriptions of how this program helped to improve patient safety in three intensive care units, and discuss the lessons learned in program implementation.

**Senior Executive Safety Walk Rounds:  
A model for senior executives to improve safety**

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## **Introduction**

Release of To Err is Human revealed the significant scope and impact of medical errors on the American population (1;2). With estimates of up to 98,000 patients dying every year from medical errors, healthcare organizations must make patient safety their paramount goal.

Healthcare leaders need to create organization-wide systems to identify and eliminate hazards that pose risks to patients. However, work occurs in a context called culture that controls the ability to identify and eliminate hazards. Leaders need to create a culture that supports patient safety.

There are specific behaviors that leaders can implement to create a culture that supports patient safety. These behaviors include the following: all staff accept that patient safety is their responsibility; leaders, staff, and patients openly communicate regarding safety concerns; leaders empower staff to identify and reduce threats to patient safety; leaders allocate resources for safety; and leaders educate staff on the science related to safety.

The Johns Hopkins Hospital (JHH) Patient Safety Committee created a safety program that focused on encouraging staff in selected units to identify and eliminate potential errors in the patient care environment. Senior hospital executives with an understanding of the critical nature of patient safety and dedication to organizational improvement were assigned as advocates to selected patient care units. The executives then worked with the unit staff to identify issues and empower staff to address safety issues. In this article we describe how we implemented this program and present case descriptions of how this program helped to improve patient safety in three intensive care units.

## **The JHH Patient Safety Program**

To improve patient safety, the JHH Performance Improvement Council created a Patient Safety Committee to organize a process involving senior executives that could be sequentially

implemented in work units. An eight step program was developed to prepare the executive, conduct a safety assessment of the unit, and provide structure to ongoing safety activities.

*Step 1: Conduct a Culture Survey.* The first step in the program is to assess the existing safety culture of the unit. A survey instrument (Exhibit 1), used within the aerospace industry, was developed utilizing a five-point Likert scale (3). The survey measures social traits, norms and practices of the unit. Participants are asked to identify their own perceptions of safety, their impression of executive leadership's commitment to patient safety, and their evaluation of fellow employees' sensitivity to current safety initiatives.

*Step 2: Educate staff on the Science of Safety.* Upon completion of the culture survey each staff member on the unit attends a briefing from a Patient Safety Committee representative on the "Science of Safety." The briefing is both quantitative and emotive and helps staff understand that adverse events are caused by system errors and that individual blame is not constructive. Further, staff are encouraged to understand their critical role in improving the environment of care in which they operate.

*Step 3: Identify staff's safety concerns through a Staff Safety Survey.* Upon completion of the briefing, a second survey is conducted to allow individuals to identify specific patient safety problems (Exhibit 2). Staff is asked to describe the last patient who could have been harmed if a staff member had not intervened. Further, staff identifies how the next patient on their unit will be harmed and what actions could be taken to prevent this harm. The results of the two surveys are tabulated to compare the unit culture with other units, to identify specific safety issues on the unit, and to serve as a baseline for future initiatives.

*Step 4: Senior executives adopt a work unit.* The fourth step of the program assigns a senior hospital executive to each work unit as the unit advocate. Before the first meeting between the unit and the advocate, members of the hospital safety program summarize the results

of the Staff Safety Survey. The results are presented in a planning meeting to assist the advocate in understanding program goals and identifying potential areas for improvement. Similar discussions occur with the medical and nursing leaders of the participating units, particularly focusing on identifying barriers that the executive advocate could mitigate.

The first meeting between the unit and the advocate involve representatives from Risk Management, Pharmacy, Hospital Epidemiology and Infection Control. In general, the unit nurse manager and physician director attend the initial meeting as well as staff nurses, physicians, pharmacists and respiratory therapists. The meeting agenda focuses on discussing unit survey results, identifying potential areas to improve and developing rapport between the advocate and the unit. Issues of patient safety that require immediate attention are immediately directed to the appropriate department. In addressing longer-term issues, units are encouraged to focus on three areas that are resource intensive and three areas that require minimal marginal resources.

At the end of the meeting, all participants agree on the areas of focus and prioritize issues. A letter summarizing results of the meeting and parties assigned responsibilities is then sent from the Patient Safety Committee to the unit and the advocate (Exhibit 3). This letter assists the unit in tracking its identified issues and responsible parties, and provides a standard format for the unit's regular reporting of activities to the Patient Safety Committee. The advocate and the unit then arrange to meet each month to conduct "walk rounds," discuss identified issues, monitor progress and continue to seek potential areas for improvement. At the end of each meeting, the Issue Identifier Worksheet (Exhibit 4) is completed and shared with meeting attendees and the Patient Safety Committee. This worksheet serves as the ongoing agenda for future walk rounds.

*Step 5: Implement improvements.* Every project conducted on the unit follows a Plan-Do-Study-Act (PDSA) cycle (4). As a problem is identified, a unit work team develops a possible solution. The solution is then implemented, the impact of the solution is studied and results acted upon. The advocate is encouraged to be an active part of the implementation process where possible. The Patient Safety Committee coaches the team and provides administrative support. Coaching efforts focus on data collection, team building and developing communication channels.

*Steps 6 and 7: Document results, share stories and disseminate results.* Results from each PDSA cycle are documented and shared among the executives, unit staff, Patient Safety Committee and other areas of the hospital. The executive advocate and staff from each unit are asked to share project successes and failures with the organization, both to maintain a knowledge base and to prevent redundancy. Exceptional projects and tools are posted on the JHM intranet site for easy access by other units. Interventions where results show no positive impact are also documented as lessons learned.

*Step 8: Resurvey staff--Cultural Survey.* Finally, each unit is resurveyed six months after entry into the program. Survey results are compared with the baseline data previously collected and trends are noted.

### **Unit Examples**

Initial implementation of this program focused on four intensive care units. The president of The Johns Hopkins University, Dean/Chief Executive Officer (CEO) of Johns Hopkins Medicine (JHM), JHH president, JHH Executive Vice President/Chief Operating Officer (COO), and VP of Human Resources for JHH were selected as the first group of advocates. We present pertinent results from four of these ICUs below.

### ***ICU 1: Example of cultural change and removing hazards***

The first visit by the Dean/CEO to the neurosciences ICU highlighted the potential for this program improving both unit safety culture and specific safety issues. During this initial meeting, the advocate was immediately aware of a lack of knowledge about institutional leadership. This fact surfaced when the unit nurse manager failed to recognize the Dean and questioned his role in the institution. Further, the physician director of the unit (a faculty member) had chosen not to attend the meeting because the physician did not consider the safety initiative a high priority.

Similarly, initial comments from the nursing staff voiced concern over staffing shortages and its potential effect on their quality of patient care. Upon hearing this comment, a physician leader representing the absent director rebuked the group for "airing dirty laundry" and felt this issue should not be discussed. The Dean interrupted, stating that the purpose of this forum was to address all unit concerns and encourage open dialogue about safety—this was the reason for his presence.

Subsequent unit dialogue revealed a broad list of nursing concerns including staff retention, unanticipated readmissions from patient wards, dysfunctional rounds, and staff's perception of poor communication between medical and nursing staff that leads to confusion over patient's daily care plans. Each concern was prioritized and then assigned a unit champion coordinate work, oversee progress and provide feedback to staff and leadership.

Several issues for immediate action emerged. For example, this ICU did not have an external pacemaker immediately available--forcing them to borrow from another ICU. While a purchase request had been submitted in the prior year, no one on the ICU had information concerning the status of the request. Upon hearing this, the Dean/CEO asked the safety program staff to contact the department administrator to inquire about the request. The purchase request

had been submitted on the wrong form; the request was in limbo. This safety issue was resolved within 72 hours. An external pacemaker was purchased and stationed on the unit.

In addition, the ICU staff expressed the desire for a point-of-care pharmacist in the ICU. A pharmacy representative was present during the rounds and stated that a point-of-care pharmacist was hired six months ago for the ICU. Upon further investigation, pharmacy staff revealed that the point-of-care pharmacist had not yet started because the computer in the ICU lacked the appropriate software to process medication orders. The ICU staff was unaware of the needed software. Consequently, the software was never ordered and the point-of-care pharmacist was not able to start working. Within two days of this meeting, the appropriate software was installed and the new pharmacist working on the unit.

These immediate responses proved critical in mobilizing ICU leadership to address longer-term safety issues still facing the unit. The ICU is now developing teams in conjunction with the safety program staff to resolve issues relating to unit staffing, missing medications and workflow. These initiatives have the potential to dramatically improve the quality of care provided on this unit. To validate this hypothesis, acuity level, number of patients admitted and readmission rates will be monitored and compared to baseline data.

### ***ICU 2: Example of removing hazards***

The surgical ICU identified patient transport as a significant safety concern. Patients were being transferred between units or to ancillary departments under the care of medical interns with limited training. Several "near miss events" had occurred in recent months during these patient transports. Within the forum of these Patient Safety Rounds, staff expressed concern over patient transport to their executive advocates--the Vice President (VP) of nursing and the COO. Further, staff was frustrated by limited funds for a dedicated transport team. For the past two fiscal years they had requested funding for a dedicated team to transport ICU

patients to and from departments within the hospital—they were given partial funding because of hospital cost pressures.

One advocate admitted that she was not aware of these cut backs in funding; however, she intervened to approve the request and assign both financial and human resources to resolve this issue. The next morning a transport team was available to provide high quality care during transport. This advocate's action produced immediate results. Staff were delighted that their opinions had been heard and quickly answered, and that safety had improved for critical care patients throughout the hospital. Indeed, the good will and trust created between administrators and staff through this action far exceeded the costs of the transport team. And, the unit's new willingness to identify additional safety initiatives was greatly enhanced.

### ***ICU 3: Example of Cultural Change:***

After participating in the survey process and attending the "Science of Safety" briefing, an ICU secretary became more aware of the activities that occurred on her unit. She took the initiative to identify two medication errors that had occurred. In the first, she identified a potential medication conflict involving a patient suffering from hypothyroidism. Her family experience with these medications raised her awareness and caused her to question a physician's medication order. She paged the attending physician and asked if he intended to prescribe two similar thyroid medications simultaneously. The attending recognized this as a mistake and adjusted the order before it reached the patient. In the second incident, she noted a medication dosage in a physician order that was inconsistent with other orders she had seen previously for the same medication. Again, she paged the attending physician to clarify the order and the attending changed the order before it was processed and dispensed to the patient.

The JHH President had been selected as the advocate for this ICU. Efforts made by the unit staff prompted the President to visit the unit and publicly commend the staff as patient safety

heroes. The clerk's actions and the advocate's recognition of the staff reverberated throughout the unit serving as a concrete example of executive leadership's commitment to patient safety.

#### ***ICU 4: Empowering Staff to Assume Responsibility for Safety***

The JHU president volunteered to meet with staff from the cardiac ICU. ICU staff had previously decided that surgical site infections were a priority. When the president asked why infection rates were so high, a senior cardiac surgeon showed pictures of dust laden light fixtures in the operating room. This surgeon stated that poor cleaning was contributing to wound infections. The JHU president then asked the team why they continued to operate under such hazardous conditions. He followed up by stating that each of us is responsible for ensuring that patients are not exposed to undue risk.

While the staff was frustrated by the dirty lights, they failed to understand their responsibility to stop operating until the hazard, dirty lights in this case, was fixed. The dynamics between staff and administration changed dramatically once the staff realized they had the power to cancel surgery if an operating room was deemed non-sterile. The balance of power immediately shifted; staff assumed responsibility for safety. That same afternoon, a cleaning team was discharged to all operating rooms, rendering them spotless.

The staff then discussed their goal to reduce rates of wound infections to the 50<sup>th</sup> percentile. The University President, knowledgeable in Toyota production methods, challenged the group to strive for 0 defects; to eliminate infections. He stated, 'if you set a modest goal, radical process redesign is less likely to occur. Only when an audacious goal is adopted are people challenged to really think about revolutionary change in processes as well as behavior.' After some discussion, staff realized they could no longer follow the status quo--they needed to assume responsibility and strive for 0 defects.

### ***ICU 5: Allocating Resources for Patient Safety***

The vice president for human resources meets monthly with the Medical ICU staff. One of the first issues the staff identified was the danger of giving a bolus of sedatives with the current pumps. Staff was concerned about several near missus regarding sedatives with the current infusion system. The staff discussed several options for reducing this risk, including the following: using the Pyxis for a bolus, using a separate bag or syringe, administering buteral through different tubing, discontinuing use of the dose calculator on the existing pump and using a new pump. Each option was piloted and a thorough evaluation completed by the nurses for each suggestion. By far, the best choice was a new pump. It solved not only this safety issue, but addressed another serious safety concern via its "guardrail" capability.

Instituting a new pump also meant added costs. With the executives support, the staff arranged to pilot test these pumps, collect data regarding their efficacy, and present the results for approval and funding. Using a new pump led to a significant reduction in medication errors. The ICUs executive helped advocate the purchase of new pumps. Despite the clinical and economic advantage, the cost to purchase new pumps for the entire hospital was significant. Fortunately, through the collaborative efforts of ICU staff and the MICU executive, funding is being considered.

### **Discussion:**

In this article, we present the experiences of senior executives who adopted a work unit, specifically ICUs, at The Johns Hopkins Hospital. We believe this novel program has already improved the culture of safety at Hopkins by encouraging staff to identify and swiftly eliminate potential hazards. Additionally, staff's belief in senior executive's commitment improved substantially. Staff quickly realized that senior leaders were dedicated to patient safety by their

willingness to dedicate time and allocate necessary resources. This program is currently active on seven ICUs and other units, such as obstetrics and emergency medicine, are preparing to initiate this program.

The experience of implementing this program has revealed several lessons that may guide others in starting such a program. First, addressing both executive and staff anxiety through regular communication proved important in fostering a positive initial meeting with the unit. Executives were presented with potential questions for discussion and a summary of the safety survey results to ensure their preparedness before meeting with the unit. In addition, the co-chairs of the Patient Safety Committee and senior leadership from a variety of departments attended the initial meeting to ensure the executive was not left "high and dry" if a specialized question or issue arose. Safety program staff also met with unit staff prior to the first meeting to encourage them to use the meeting as a forum for engaging the advocate in a meaningful dialogue to address their unit's needs.

Second, the executive must maintain a consistent level of involvement and commitment to improve patient safety. Executives do not need to have clinical knowledge, but rather an understanding of organizational infrastructure, genuine concern for unit needs and a passion for patient safety. The participating executives must communicate effectively with the unit and focus on creating a real change in the safety culture of their assigned unit. Executives most effective in facilitating cultural change focus on systems rather than people, reward staff as heroes for actively seeking safety, allocate resources to improve safety, and actively eliminate safety hazards. The unit, seeing the continued presence of the executive, begins to envision a bridge between patient care needs and management or organization-level resource allocation. Once an executive is assigned to a unit, that executive is encouraged to continue to serving as an advisor or advocate for that unit as long as the relationship is positive for both entities.

Third, middle management must be engaged if this program is to be successful. While the initial program was designed with as a partnership between the executive advocate and unit staff, it was soon apparent that middle management provided a key link in resolving identified safety issues. As the stories in ICU 1 and 2 suggest, staff did not effectively communicate their safety concerns to their administrators (e.g. division managers or functional unit administrators.) However, middle management provided essential support in enacting the plans of executive leadership. Therefore, we now incorporate departmental administration into the program and encourage administrators to attend Senior Executive Walk Rounds. Additionally, administrators are asked to identify barriers that they have removed to improve patient safety, identify someone they have publicly rewarded for their safety consciousness, and ask themselves how they exemplified excellence in safety. These activities will be regularly monitored and reported to the Patient Safety Committee.

Fourth, discussions from meetings should build a working agenda. After several iterations, we developed an Issue Identifier Worksheet (Exhibit 4) to summarize meeting results. At the end of each meeting, issues are summarized and an action list created with the appropriate champion. A memo describing the meeting is sent to all attendees and used as the next month's agenda. This approach provides a practical yet robust method to monitor the teams' progress.

Fifth, many staff, including senior staff, have not accepted responsibility for patient safety. Efforts to empower staff to stop the production process, such as the operating room schedule, when patients are exposed to known hazards are essential. Most staff in healthcare have yet to feel comfortable assuming this responsibility.

Finally, cultural change in an organization occurs sequentially on a unit by unit basis. Frontline staff's commitment is fundamental to fostering environmental and behavioral change on a patient care unit. Program support in fostering this change, through facilitating meetings,

tracking initiatives, conducting surveys and resolving identified problems, is considerable.

Hence, we have chosen to focus our available time and effort on just two or three units at one time. Each unit receives dedicated attention for six months, the time needed to complete the eight-step program. After this period, each unit is asked to sustain the program with minimal support from the Patient Safety Committee. We believe this focused effort on building unit level enthusiasm and commitment can create incremental cultural change throughout the hospital and result in an organization-wide commitment to safety.

### **Summary**

The senior executive adopt-a-work unit program was successful in identifying and eliminating hazards to patient safety and in creating a culture of safety. This program can be broadly implemented. The keys to program success are the active role of an executive advocate and the willingness of staff to openly discuss safety issues on their unit. Regular meetings between the advocates and the units have provided a forum for enhancing executive awareness, increasing staff confidence and trust in executive involvement, and swiftly and effectively addressing areas of potential patient harm. We believe this program will continue to spark significant improvements in both the safety environment and culture at The Johns Hopkins Hospital.

### **Reference List**

- (1) To err is human: building a safer health system. Kohn L, Corrigan J, Donaldson M, editors. Institute of Medicine Report . 2000. Washington, DC, National Academy Press.  
Ref Type: Serial (Book, Monograph)
- (2) Reason J. Human error: models and management. Brit Med J 2000; 320:786-770.

- (3) Sexton J, Helmreich R, Williams R, Merritt A, Klinec J. The Flight Management Attitudes Safety Survey (FMASS). Research Project Technical Report 01-01. 2001. Austin, TX, The University of Texas.

Ref Type: Report

- (4) Lighter D, Fair D. Principles and methods of quality management in health care. 2000. Gaithersburg, MD, Aspen Publishers, Inc.

Ref Type: Serial (Book, Monograph)

## Exhibit 1: Cultural Survey Questionnaire

*We are conducting a survey to evaluate the culture of safety in your unit. The survey will take **three minutes to complete**. Please leave the completed survey in the survey mailbox or with the designated point of contact from your unit.*

**Role** (circle one): Attending / Fellow Physician / Resident Physician / Nurse / Respiratory Therapist / Support Associate / Other (please list): \_\_\_\_\_

**Unit** (i.e., MICU, WICU, etc.): \_\_\_\_\_

**Date** \_\_\_\_\_

*Please circle one answer per question*

1. The senior leaders in my hospital listen to me and care about my concerns.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
2. The physician and nurse leaders in my area listen to me and care about my concerns.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
3. My suggestions about safety would be acted upon if I expressed them to management.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
4. Management/Leadership will never compromise safety concerns for productivity.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
5. I am encouraged by my supervisors and coworkers to report any unsafe conditions I observe.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
6. I know the proper channels for reporting my safety concerns.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
7. I am satisfied with availability of clinical leadership (MD, RN, RPh)	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
8. Leadership is driving us to be a safety-centered institution.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
9. I am aware that patient safety has become a major area for improvement in institution.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1
10. I believe that most adverse events are the result of multiple system failures, and are not attributable to one individual's actions.	Agree 5	Somewhat Agree 4	Neutral 3	Somewhat Disagree 2	Disagree 1

**Thank you for engaging in patient safety!**

## **Exhibit 2: Staff Safety Survey**

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Name:  
Role  
Date:  
Unit:

Please describe how you prevented a patient from being harmed.

Please describe how the next patient in your work area will be harmed.

Please describe how we can prevent this harm.

Please describe how we can make the potential harm visible before it happens.

If the patient were to suffer this harm, how could we reduce the harm?

**Thank you for helping improve safety in your workplace!**

**Exhibit 3: Summary Letter of First  
Executive Walk Round**

**[UNIT CONTACT]**  
**[DATE]**

Dear **[UNIT CONTACT]**,

The Patient Safety Committee thanks you for your participation in the Comprehensive Patient Safety Program. A key component of the program is the tracking of unit initiatives and their status. During the initial NCCU/NVICU Senior Executive Walk Round a number of issues were identified that need to be addressed. In order to keep track of activities within the program, including progress towards meeting your goals and identification of new issues, it would be helpful for you to keep track of your issues in a standard format as seen below. After each round please update the template and forward to **[Patient Safety Committee]**. Below are the issues identified in the first Executive Walk Round.

<i>Safety Issue</i>	<i>Contact</i>	<i>Status</i>	<i>Goal</i>
		•	
		•	
		•	
		•	
		•	
		•	
		•	
		•	
		•	

Sincerely,

Acting members of the Patient Safety Committee

## **Exhibit 4: Issue Identifier Worksheet**

**Date of Walk Rounds:**

**Unit:**

**Attendees:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

<b><i>Identified Issue</i></b>	<b><i>Potential/Recommended Solution</i></b>	<b><i>Point of Contact (Unit or otherwise)</i></b>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

**Note:** Please return this and any additional notes to the Sharon Mears, located in Billings Administration, room 129, FAX: 4-9981. If you have any questions please call (5-0620) at your earliest convenience. Thank you for your support and dedication in helping to change our culture and put patient safety at the forefront of the organization.